

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152568		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/30/2012	
NAME OF PROVIDER OR SUPPLIER DAVISS COUNTY DIALYSIS				STREET ADDRESS, CITY, STATE, ZIP CODE 310 NE 14TH ST WASHINGTON, IN 47501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{V 000}	<p>INITIAL COMMENTS</p> <p>This was a revisit for the federal recertification survey completed on 4-16-12.</p> <p>Facility #: 002590</p> <p>Survey Dates: 5-30-12</p> <p>Medicaid Vendor #: 200285170A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Census: 46 incenter hemodialysis, 0 home dialysis</p> <p>One Condition for Certification and 16 standard level deficiencies were found corrected during this survey.</p> <p>Daviess County Dialysis was found to be in compliance with the Condition for Certification 42 CFR 494.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 4, 2012</p>			{V 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.